URA LOGO, ADDRESS, ETC., AND TDI URA CERTIFICATION NUMBER

THIS IS A NOTICE OF ADVERSE DETERMINATION-SPECIALTY HEALTH

Re: [*describe health care services or treatment that URA is denying*]

On behalf of _____[*insert name of health plan/payor*], we decided that the services or treatments described above [*are not medically necessary*] [*are experimental or investigational*]. This means that we do not approve these services or treatment.

- The principal reason(s) for denying these services or treatment: [*insert principal reason*].
- The clinical basis for denying these services or treatment: [*insert clinical basis*].
- The physician or health care practitioner who reviewed your request or claim specializes in [*insert specialty of reviewer*].
- The screening criteria or guidelines that we used to make the decision: [*insert source and/or description of screening criteria*].

Our Internal Appeal Process

The enrollee or someone acting on the enrollee's behalf and the provider of record have the right to appeal this adverse determination orally or in writing. A physician or other health care provider who has not previously reviewed the case will make the appeal decision. The appealing party must send us the appeal no later than [____] days after the date of this letter {*can be no less than 30 days*}.

- **Written Appeal:** To submit a written appeal, mail or fax the written appeal to the following address or fax number: [*insert URA's address and fax number*]**.**
- **Oral Appeal:** To file an oral appeal, call the following toll-free number: [*insert URA's toll-free number*].

There are two types of appeals:

- **Standard Appeal:** An appeal that does not involve urgent care such as emergency care, life-threatening conditions, or continued hospitalization.
- **Expedited Appeal:** An expedited appeal is available for emergency care, life-threatening conditions, and hospitalized enrollees.

Appeal Acknowledgment: Within five working days of receipt of the appeal, we will send the appealing party a letter acknowledging the date that we received the appeal and a list of documents that we may need for the appeal. If the appeal is oral, we will send the appealing party a one-page appeal form. The appealing party does not have to return the appeal form but we encourage its return because the form will help us resolve the appeal.

Our deadlines to resolve the appeal and send a written decision to the enrollee or someone acting on the enrollee's behalf and the provider of record are:

- **Standard Appeal:** 30 calendar days of receipt of the appeal
- **Expedited Appeal:** One working day from the date we receive all information necessary to complete the appeal. We may provide the determination by telephone or electronic

transmission, but will provide a written determination within three working days of the initial telephonic or electronic notification.
- **Retrospective (claim) Appeal**: 30 calendar days after receipt of appeal. However, we may extend this deadline once for a period not to exceed 15 days.

Life-Threatening Conditions: If the patient has a life-threatening condition, the patient, or someone acting on the enrollee's behalf, and the provider of record can request an immediate review by an independent review organization (IRO) and is not required to follow our internal appeal procedures. See below for more information about the IRO review.

Exhaustion of Internal Appeals: We will not require exhaustion of our internal appeals process if: (a) we fail to meet our internal appeal process timelines, or (b) the claimant with an urgent care situation (life-threatening condition) files an external review before exhausting our internal appeal process.

Independent Review

If we deny the appeal (continue to deny the services or treatment described above), the enrollee or someone acting on the enrollee's behalf and the provider of record have the right to request a review by an IRO. The IRO does not have an affiliation with your payor (insurance company or health plan), your health care providers, or the URA.

To request the IRO review, fill out the enclosed TDI form (LHL009) and return it to the address noted in the form or this letter. The patient or the patient's legal guardian must sign the consent to release medical information to the IRO (included as part of the IRO form).

Complaint Procedures

- **You can send a complaint to us (the URA):** Enrollees, individuals acting on behalf of enrollees, and health care providers may file a written or oral complaint about our utilization review process or procedures. Use the telephone numbers and address referenced above to file your oral or written complaint. We will respond to your complaint in writing within 30 days.
- **Complaints to TDI:** A complainant also has the right to file a complaint with TDI by contacting TDI at the following address, telephone numbers, or website:

  Texas Department of Insurance
  PO Box 149091
  Austin, TX 78714-9091
  1-800-252-3439
  Fax: 512-490-1007
  Online: www.tdi.texas.gov

CC: {Enrollee or Person Acting on Enrollee's Behalf}
{Physician/Provider of Record}

Attachment: TDI LHL009 Form